

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. **79-22672**

1. DECEASED NAME (TYPE OR PRINT) <b>LOFTON BELLAMY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-5-79</b>		2b. HOUR <b>8:30p</b> M
3. SEX <b>MALE</b>	4. RACE <b>NEGRO</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>UNKNOWN 1921</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>CHARLES</b> MD.		
10. CITY OR TOWN OF DEATH <b>LA PLATA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PHYSICIANS MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY —
13a. STATE <b>Md.</b>	13b. COUNTY <b>CHARLES</b>	13c. CITY OR TOWN <b>Rock Point</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS —	
14. FATHER'S NAME FIRST MIDDLE LAST <b>PINK BELLAMY</b>	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CORA Eagles</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		
16b. SOCIAL SECURITY NO. <b>246-18-8744</b>		17. INFORMANT ADDRESS <b>Ruth Ardrey New York</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> <b>7863</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>massive Haemoptysis</b> DUE TO, OR AS A CONSEQUENCE OF (c) —					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>July 19 79</b> to <b>9-5-1979</b> , that (I) (we) lost saw the deceased alive on <b>7-18-1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we did not) view the body after death.					
22b. SIGNATURE <b>G.S. Rath</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G.S. RATH, M.D.</b>		22e. ADDRESS <b>Charles Professional Bldg. Waldorf, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9-14-79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>4661 Surfland P.G. Md.</b>
24. FUNERAL DIRECTOR NAME <b>LEON THORNTON</b>		25. DATE REC'D. BY REGISTRAR <b>SEP 20 1979</b>		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
27. FUNERAL HOME <b>THORNTON FUNERAL HOME POMOKEY, MD</b>					

BP.

77-22672



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 2 6 7 3

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR PM	
Charles William Bowie, Sr.				September 26, 1979		10:50 AM	
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS	
Male	White	July 25, 1917		62 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	U.S.A.			Charles MD			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
La Plata	Physicians Memorial Hosp.			Planner-Estim.		U.S. Govt.	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
MD.	Charles	Indian Head	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	161 M Rt.#2			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Maximillian Bowie				Maggie Bowie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes		WW11		201-10-0274 Agnes C. Bowie same as 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Candida Arrest</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3330							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Shy Dragger Disease.</u>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8-11</u> 19 <u>79</u> to <u>9-26</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>9-26</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Shonath</u>				DEGREE <u>MD.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9-27-79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Shankar G. Rath M.D.				Chas. Pfof. Center Waldorf, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		9-29-79		St. Charles Cem.		Glymont Charles Maryland	
24 FUNERAL DIRECTOR NAME				24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
Huntt Funeral Home				Waldorf, Md.		OCT 01 1979	



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## MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO. 7 9 2 2 6 7 4	
1. DECEASED NAME (TYPE OR PRINT) <b>HARRY Blaine Chamberlain</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>Sept 20</b>		2b. HOUR <b>8:30</b> M	
3 SEX <b>male</b>	4 RACE <b>Cau.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 2, 1913</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Calif.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD	
10. CITY OR TOWN OF DEATH <b>La Plata</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sound Tec.</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Charles</b>	13c. CITY OR TOWN <b>Indian Head</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Louis Chamberlain</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cora Unavailable</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW II 567-9410</b>		17. INFORMANT ADDRESS <b>Robert K. Chamberlain same as 13</b>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Raynaud's Colic</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary of Lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Bronchitis</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9-25 19 78</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9-25 19 78</b> to <b>9-20 19 79</b> , that (I) (we) last saw the deceased alive on <b>9-20 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Dr. Woody</b>		DEGREE		22c. DATE SIGNED <b>9-20-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. Woody, M.D.</b>		22e. ADDRESS <b>La Plata Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-24-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Mem. Garden</b>	
23d. LOCATION CITY OR TOWN <b>Waldorf, Charles, Md.</b>		23e. COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Hunt Funeral Home, Waldorf, Md.</b>		25a. DATE REC'D BY REGISTRAR <b>SEP 26 1979</b>			

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*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "State", "County", and "City" are faintly visible.]*

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1 - FOR STATE REGISTRAR					7 9 2 2 6 7 5 REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Shannon Oliver Davis					2a. DATE OF DEATH MONTH DAY YEAR 9-12-1979 5:30 A.M.					
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR June 6, 1895		6 AGE (IN YEARS LAST BIRTHDAY) 84		7b. HOUR 30		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Charles MD				
10 CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicans Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Coal Miner Ret.		12b. KIND OF BUSINESS OR INDUSTRY Coal Mining		
13a. STATE Maryland			13b. COUNTY Charles		13c. CITY OR TOWN Pisgah		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
14 FATHER'S NAME FIRST MIDDLE LAST William Davis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Glady's Jane Deshong			17. INFORMANT 17704 Mac Arthur Blvd. George Davis-Son Rockville, Maryland				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 161-12-6183 A							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 410- DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 years										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE-FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 9-12-79 to 9-12-79 that (I) (we) last saw the deceased alive on 9-12-79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Daniel Howell M.D.						DEGREE MD		22c. DATE SIGNED 9-12-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL HOWELL M.D.						22e. ADDRESS Waldorf Md 20601				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/14/79		23c. NAME OF CEMETERY OR CREMATORY Everett Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Everette, Bedford Co., Penn.			
24. FUNERAL DIRECTOR Funeral Home - Everett, Pennsylvania Chester Funeral Home, Inc. - La Plata, Md.						DATE REC'D. BY REGISTRAR SEP 17 1979		25b. REGISTRAR'S SIGNATURE [Signature]		

BP



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524M C-9.72



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 1 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

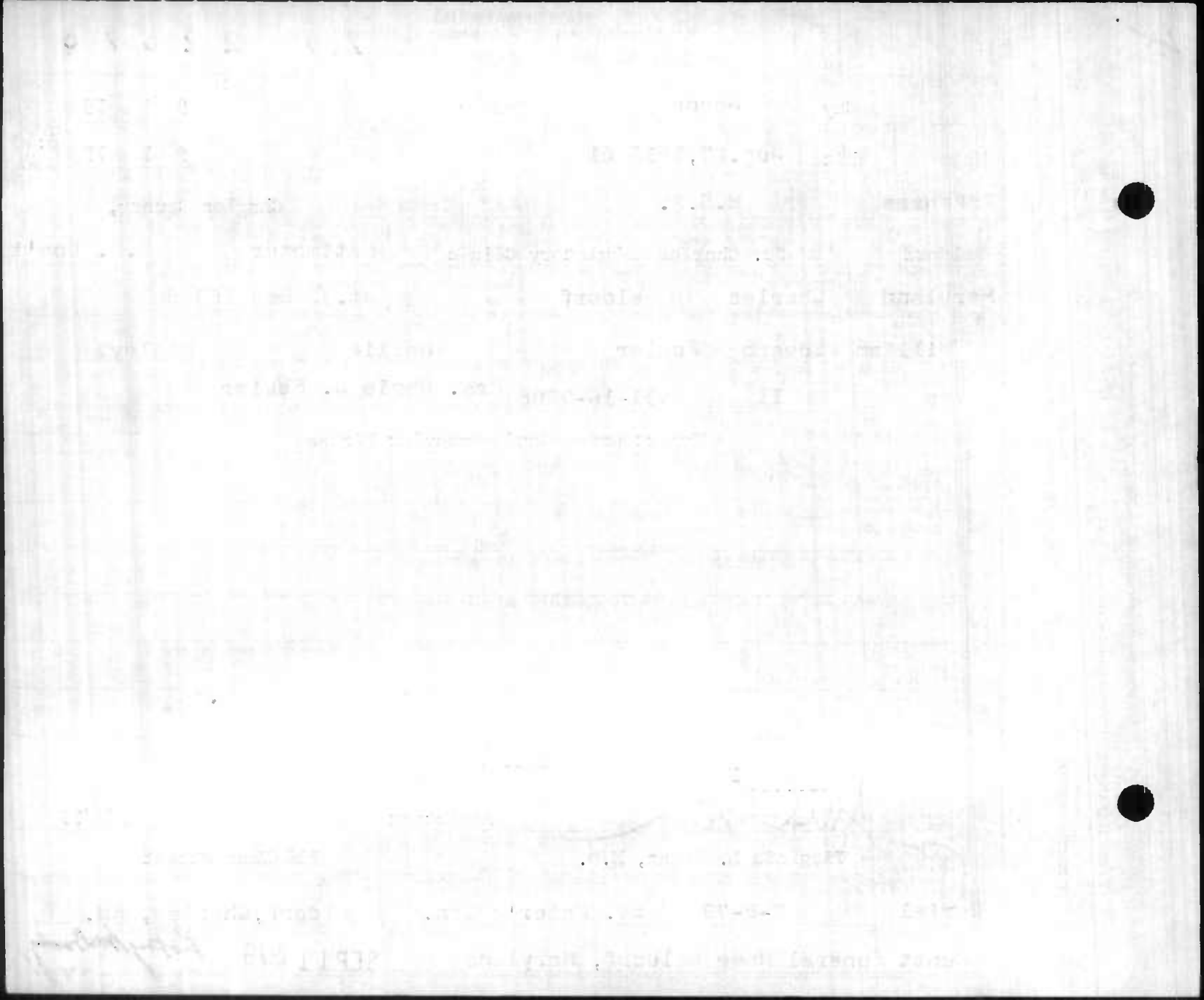
DPHMH-17  
(VIR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

22676

1. FOR STATE REGISTRAR										2. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 9 4 79										7b. HOUR M 6:40 P A																																							
1a. DECEASED NAME (TYPE OR PRINT) Coy Wayne Fowler										2c. DATE PRONOUNCED DEAD 9 4 79										7d. HOUR M 6:40 P A																																							
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH YEAR DAY Aug. 27, 1918		6. AGE (IN YEARS) LAST BIRTHDAY 61 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Charles County, MD.																																					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arkansas										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										10. CITY OR TOWN OF DEATH Waldorf										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Charles Ambulatory Clinic										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Estimator										12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't									
13a. STATE Maryland										13b. COUNTY Charles										13c. CITY OR TOWN Waldorf										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET ADDRESS Rt. #2 Box 269 B																			
14. FATHER'S NAME FIRST MIDDLE LAST William Edward Fowler										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mallie Wigley										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes										16b. SOCIAL SECURITY NO. 431-10-7908										17. INFORMANT ADDRESS Mrs. Doris J. Fowler																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease 4029 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																																							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE																																							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																																																	
ACTUAL SIGNATURE <i>Virginia L. Dolan</i>										TITLE (SPECIFY) Assistant										DATE SIGNED 9/5/79																																							
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.										ADDRESS 111 Penn Street																																																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 9-8-79										23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cem.										23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf, Charles, Md.																													
24. FUNERAL DIRECTOR NAME Huntt Funeral Home										ADDRESS Waldorf, Maryland										25a. DATE REC'D. BY REGISTRAR SEP 11 1979										25b. REGISTRAR'S SIGNATURE <i>History</i>																													



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 2 6 7 7

1. STATE REGISTRAR		2. DATE KNOWN OF DEATH		3. MONTH DAY YEAR		4. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2. DATE KNOWN OF DEATH		3. MONTH DAY YEAR		4. HOUR	
BESSIE M. GOINGS		9 27 19 79		10:12 P			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. DATE PRONOUNCED DEAD	10. MONTH DAY YEAR
female	white	April 5-03	76 YRS			9 27 19 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. NEVER MARRIED	10. WIDOWED	11. DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH	
Virginia	USA					Charles County MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
LaPlata	Physician's Memorial	Homemaker	---				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
Maryland	PG	Suitland	YES X NO	3528 Terrace Drive			
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME						
Walter Sexton	Mae Callhan						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS				
No	577 28 9984	Donald E. Goings	5823 Burke manor				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease							
IMMEDIATE CAUSE (a)							
DUE TO, OR AS A CONSEQUENCE OF							
(b)							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
						YES NO X	
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
WHITE NOT WHITE				CITY OR TOWN COUNTY STATE			
AT WORK AT WORK							
22a. I certify that I took charge of the remains described above, held an Autopsy Inspection, and in my opinion death resulted from: Natural causes X Accident Suicide Homicide Undetermined manner							
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED	
Margarita A. Korell, M.D.		Assistant				9/28/79	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
Margarita A. Korell, M.D.		111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	COUNTY	STATE	
Burial	1 Oct 1979	Washington National		Suitland	PG	MD	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert E. Wilhelm		OCT 0 4 1979		Margarita A. Korell			
Funeral Home Inc		Suitland, Md.					

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 22678

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Lelia Anne Hayes</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-3-79</b>		2b. HOUR <b>7:28P M</b>				
1 SEX <b>F</b>		4 RACE <b>02</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>3 25 06</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Hughesville, Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD			
10. CITY OR TOWN OF DEATH <b>La Plata</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Taylor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Union</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Waldorf</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Stavors, Rd. R.R. Box 260 N</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>John Herbert</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha Buckler</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>577-12-4452</b>		17 INFORMANT ADDRESS <b>Betty E. Shipp same as 13</b>					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gen. arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs. 10 yrs.</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus, aortic valve disease, peripheral arterial disease</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>9/3</b> 19 <b>79</b> to <b>9/3</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>9/3</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.									
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Arturo M. Monteiro M.D.</b>			22c. ADDRESS <b>La Plata, MD. 20646</b>			22d. DATE SIGNED <b>9/4/79</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>9-7-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wash. Nat. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, P.G. Maryland</b>		
24 FUNERAL DIRECTOR NAME ADDRESS <b>Huntt Funeral Home Waldorf, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>SEP 10 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Patricia McCready</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

U.S. DEPARTMENT OF AGRICULTURE

THE

UNITED STATES OF AMERICA

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IN

WITNESS

BEFORE ME, the undersigned authority, on this day personally appeared

and acknowledged to me that he executed the foregoing instrument as his free act and deed.

Notary Public in and for the State of

My commission expires on the day of 19

My office is at

My term of office for years

My salary is \$

My commission was issued on the day of 19

My commission was renewed on the day of 19

My commission was renewed on the day of 19

My commission was renewed on the day of 19

My commission was renewed on the day of 19

Notary Public in and for the State of

My commission expires on the day of 19

4

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 22679

1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARNOLD F. JACKSON							2a. DATE KNOWN OF DEATH MONTH DAY YEAR 9 5 1979		2b. HOUR M 8:39 P
1. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Dec. 31, 1913	6. AGE (IN YEARS) LAST BIRTHDAY 65 YRS.	IF UNDER 1 YR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 5 1979	2b. HOUR M 8:39 P		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles County MD			
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Policeman	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Newburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. #1, Box # 99M	
14. FATHER'S NAME FIRST MIDDLE LAST Frank G. Jackson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie Berry					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 578-62-0949		17. INFORMANT ADDRESS Virginia Jackson Same as 13 a-e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease 4292 IMMEDIATE CAUSE (a) } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) } DUE TO, OR AS A CONSEQUENCE OF (c) }									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE Ann M. Dixon, M.D.				TITLE (SPECIFY) Assistant		MEDICAL EXAMINER 111 Penn St.		DATE SIGNED 9-6-79	
EXAMINER'S NAME (TYPE OR PRINT) ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 8, 79		23c. NAME OF CEMETERY OR CREMATORY St. Barnabas Epis.		23d. LOCATION CITY OR TOWN COUNTY STATE Oxen Hill P.G. Md		25a. DATE RECORDED BY REGISTRAR SEP 17 1979	
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Clinton, Maryland				25b. RECORDED BY REGISTRAR SEP 17 1979					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO. 719 22680	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Clarence Roy Jenkins</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 26, 1979</b>		2b. HOUR <b>4:05A</b> M
3 SEX <b>Male</b>	4 RACE <b>white</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>June 6 1923</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD		10. CITY OR TOWN OF DEATH <b>LaPlata</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Line Repairman</b>		12b. KIND OF BUSINESS OR <b>Construction</b>		13a. STREET ADDRESS <b>Route 301 General Delivery</b>	
13b. COUNTY <b>Maryland</b>		13c. CITY OR TOWN <b>Bel Alton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Clarence Norman Jenkins</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jessie Hardesty</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WW 11</b>	
16b. SOCIAL SECURITY NO <b>278-20-0993</b>		17 INFORMANT <b>Linda Stine</b>		ADDRESS <b>Rt. 1, Box 102 H Newburg, MD. 20664</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>alcoholic Hepatitis</b> 5711 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chl alcoholism</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>20 yrs +</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>N/A</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>N/A</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>N/A</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>9/20</b> 19 <b>79</b> , to <b>9/26</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>9/25</b> 19 <b>79</b> , and that (in (my) (our) opinion) death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Paul E. Pritchett</b> MD		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/26/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Paul E. Pritchett, M.D.</b>		22e. ADDRESS <b>LaPlata, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-28-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Episcopal Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Newport Charles Maryland</b>		24. FUNERAL DIRECTOR <b>Amant Funeral Home, Inc. Address: Plata, MD. 20686</b>			
25a. DATE REC'D. BY REGISTRAR <b>9/28/79</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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Dr. J. L. ...

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Physician's Memorial Hospital

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	10-2-1979	Mount Olivet Cemetery	Washington,	D.C.	
24. FUNERAL DIRECTOR (NAME AND ADDRESS)	25a. DATE REC'D. BY REGISTRAR				
Funeral Home, Inc., La Plata, Maryland	OCT 04 1979				
25b. REGISTRAR'S SIGNATURE			25c. REGISTRAR'S SIGNATURE		
			Dorothy McCreedy		

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 9-18-1979 to 9-29-1979, that (1) (we) lost saw the deceased alive on 9-28-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE hsnath		DEGREE M.D.		22c. DATE SIGNED 9/29/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Girija S Rath, M.D.		22e. ADDRESS Waldorf, Md. 20601			

1. FOR STATE REGISTRAR			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			7 9 2 2 6 8 1 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret Mae Larner						2a. DATE OF DEATH MONTH DAY YEAR September 29, 1979			2b. HOUR 8:35A M		
3. SEX female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 10, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.					
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY at home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN La Plata		13d. STREET ADDRESS Box 68, 302 Harford Street					
14. FATHER'S NAME FIRST MIDDLE LAST John Newman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Whitmore							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 577-10-8980 B		17. INFORMANT ADDRESS Thomas P. Larner-Box 68 La Plata, MD. 20646							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

Pancytopenia

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

8:33A

September 28, 1972

Harner

Wage

Margaret

female

white

1100 W. 11th

73

Charles

La Plaza

Physicians Memorial Hospital

Albuquerque

1100 W. 11th

Charles

La Plaza

1100 W. 11th

1100 W. 11th

1100 W. 11th

1100 W. 11th

1100 W. 11th

1100 W. 11th

1100 W. 11th

Harbord, Md. 20601

Christa S. Keith, M.D.

Christa S. Keith, M.D.  
1100 W. 11th  
Albuquerque, N.M. 87102

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 2 6 8 2

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>SAMUEL Conrad Linton SR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 30 1979</b>			2b. HOUR <b>2:45 PM</b>			
3. SEX <b>Male</b>		4. RACE <b>Cau.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 21 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.			
10. CITY OR TOWN OF DEATH <b>La Plata.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manrover</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>md. Tobacco Grow.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b> 13b COUNTY <b>Chas</b> 13c CITY OR TOWN <b>Nantemo.</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Box 109 Nantemo 20662</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frederick William Linton</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Ann Gray</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-14-7089</b>		17. INFORMANT ADDRESS <b>Elizabeth Linton Wallace, daughter Canchocken, Penna.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiovascular Collapse.</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Posterior Barrovascular</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>5 years.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Self imposed Starvation.</b>									
19a. DATE OF OPERATION <b>29</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 4 1970</b> to <b>30 Sept 1979</b> , that (I) (we) last saw the deceased alive on <b>30 Sept 1979</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE <b>Arthur O. Woodydy MD</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>30 Sept 79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARTHUR O. WOODYDY MD</b>				22e. ADDRESS <b>Box 430 LA PLATA, MD 20646</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-3-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Old Durham Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Irondides Chas. Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Huntt Funeral Home</b>				ADDRESS <b>Waldorf, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 4 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur O. Woodydy</b>	

BP

DHMH-16 25M  
(VRA 15, 4) 1/79

1955

2000

1000

500

250

125

62.5

31.25

15.625

7.8125

3.90625

1.953125

0.9765625

0.48828125

0.244140625

0.1220703125

0.06103515625

0.030517578125



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		7 9 2 2 6 8 3		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JAMES EDWARD Malloy</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Sept. 22, 1979</b>		2b. HOUR <b>8:20 A.M.</b>	
3. SEX <b>M</b>		4. RACE <b>Cauc</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 29 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>66</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.	
10. CITY OR TOWN OF DEATH <b>La Plata</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>201 St. Marys Ave.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Priest</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Priest</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>LA PLATA</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas J. Malloy</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ellen Dunn</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>579-60-8260</b>		17. INFORMANT ADDRESS <b>Sister Ann Parker-Rt. 1, Box 1011 20646 La Plata, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASWD</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Metastatic Carcinoma of lung</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>19 79</b> to <b>Sept 22</b> , 19 <b>79</b> , that (1) (we) last saw the deceased alive on <b>Sept 22</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Henry J. Burke MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>9-22-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Henry Burke</b>				22e. ADDRESS <b>La Plata, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-26-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR NAME <b>Arehart Funeral Home, Inc.</b>				ADDRESS <b>La Plata, Maryland</b>		25a. DATE RECEIVED BY REGISTRAR <b>SEP 25 1979</b>	
				25b. REGISTRAR'S SIGNATURE <b>Henry McElroy</b>			

2000

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 9 22684

1. DECEASED NAME (TYPE OR PRINT) George Garner Matthews		2a. DATE OF DEATH MONTH DAY YEAR September 9, 1979		2b. HOUR 1:15 A.M.	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 2, 1902	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Real Estate Broker/Self employ.		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. CITY OR TOWN Newburg		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Francis Weems Matthews		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Garner		16. SOCIAL SECURITY NO. 219-30-4079	
17. INFORMANT Dorothy D. Matthews-Newburg, MD.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure.</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Heart Disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Carcinoma of Rectum and Tonsils</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <u>9-5-1979</u> to <u>9-9-1979</u> , that (I) (we) lost saw the deceased alive on <u>9-8-1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>G.S. Rath</u>		DEGREE M.D.		22c. DATE SIGNED 9/9/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G.S. Rath, M.D.		22e. ADDRESS Charles Professional Bldg. Waldorf, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-12-1979		23c. NAME OF CEMETERY OR CREMATORY Mount Rest Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE La Plata Charles Maryland		24. FUNERAL DIRECTOR Name Address Archibut Funeral Homes, Inc. - La Plata, Md.			
25a. DATE REC'D. BY REGISTRAR SEP 13 1979		25b. REGISTRAR'S SIGNATURE <u>Anthony M. ...</u>			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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George Gannett      Matthew      August 9, 1927      112 A

Male      Caucasian      April 3, 1902      77

...      Charles

In State      Tyndall Memorial Hospital      ...

...      ...      ...

...      ...      ...

51-30-107      ...      ...

Henry L. Burke, M.D.      Charles International T.H.      ...

...      ...      ...

...      ...      ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 2 2 0 8 5

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>William Thomas Mattingly</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 4, 1979</b>		2b. HOUR 9:00P M
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 16, 1901</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.		
10. CITY OR TOWN OF DEATH <b>La Plata</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Painter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Charles</b>	13c. CITY OR TOWN <b>Indian Head</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>Jenkins Lane Box 149 F</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Bernard Mattingly</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura Bowie</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-44-3723</b>	17. INFORMANT ADDRESS <b>Maude L. Mattingly same as 13</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC RESPIRATORY INFECTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>PSEUDOMONAS AEROBACTER, YEAST INFECTIONS</b> Approximate interval between onset and death: <b>2-3 weeks</b> <b>1 1/2 months</b> <b>1 1/2 months</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CVA with left hemiplegia, urinary tract infection, Anemia, DECUBITUS ULCERS</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>JULY 26</b> , 19 <b>79</b> , to <b>SEPTEMBER 4</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>SEPT. 4</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Aurelio C. de la Paz, M.D.</b>		DEGREE <b>M.D.</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>9-04-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Aurelio C. Dela Paz</b>		22e. ADDRESS <b>La Plata, Maryland 20646</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>9-8-79</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Mem. Garden</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Waldorf, Charles, Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Huntt Funeral Home Waldorf, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 11 1979</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

BP

September 4, 1972 Meeting

15 10:15 AM

Charles

La Plata Psychiatric Memorial Hospital

La Plata Psychiatric Memorial Hospital

La Plata Psychiatric Memorial Hospital

La Plata Psychiatric Memorial Hospital

La Plata Psychiatric Memorial Hospital

La Plata Psychiatric Memorial Hospital

La Plata Psychiatric Memorial Hospital

La Plata Psychiatric Memorial Hospital

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La Plata Psychiatric Memorial Hospital

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				9 2 2 0 8 6			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>William Elzare Mudd</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>September 2, 1979</b>		2b. HOUR <b>9:14A</b> M	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 13, 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD	
10. CITY OR TOWN OF DEATH <b>LaPlata</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Pomfret</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William E. Mudd</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Constance Mudd</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>217-36-5564</b>		17. INFORMANT ADDRESS <b>Margaret C. Mudd, Rt. 2, Box 74-T. Pomfret Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>496-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>COPD</b> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CVA</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from <b>8-18</b> , 19 <b>79</b> , to <b>8-25</b> , 19 <b>79</b> , that (b) (we) lost saw the deceased alive on <b>8-25</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (a) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Henry L. Burke, M.D.</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>9-2-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Henry L. Burke, M.D.</b>				22e. ADDRESS <b>LaPlata, Maryland 20646</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-5-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Josephs Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pomfret Chas. Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Huntt Funeral Home, Waldorf, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 10 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McBratney</b>	

BP.



September 2, 1959      10:15A

Mr. Charles E. ...  
Theodore Memorial Hospital  
Rt. 2, Box 74-1  
217-36-5584  
Mr. E. ...

Henry I. Burke, M.D.  
Lafayette, Maryland 20646

217-36-5584  
Mr. E. ...

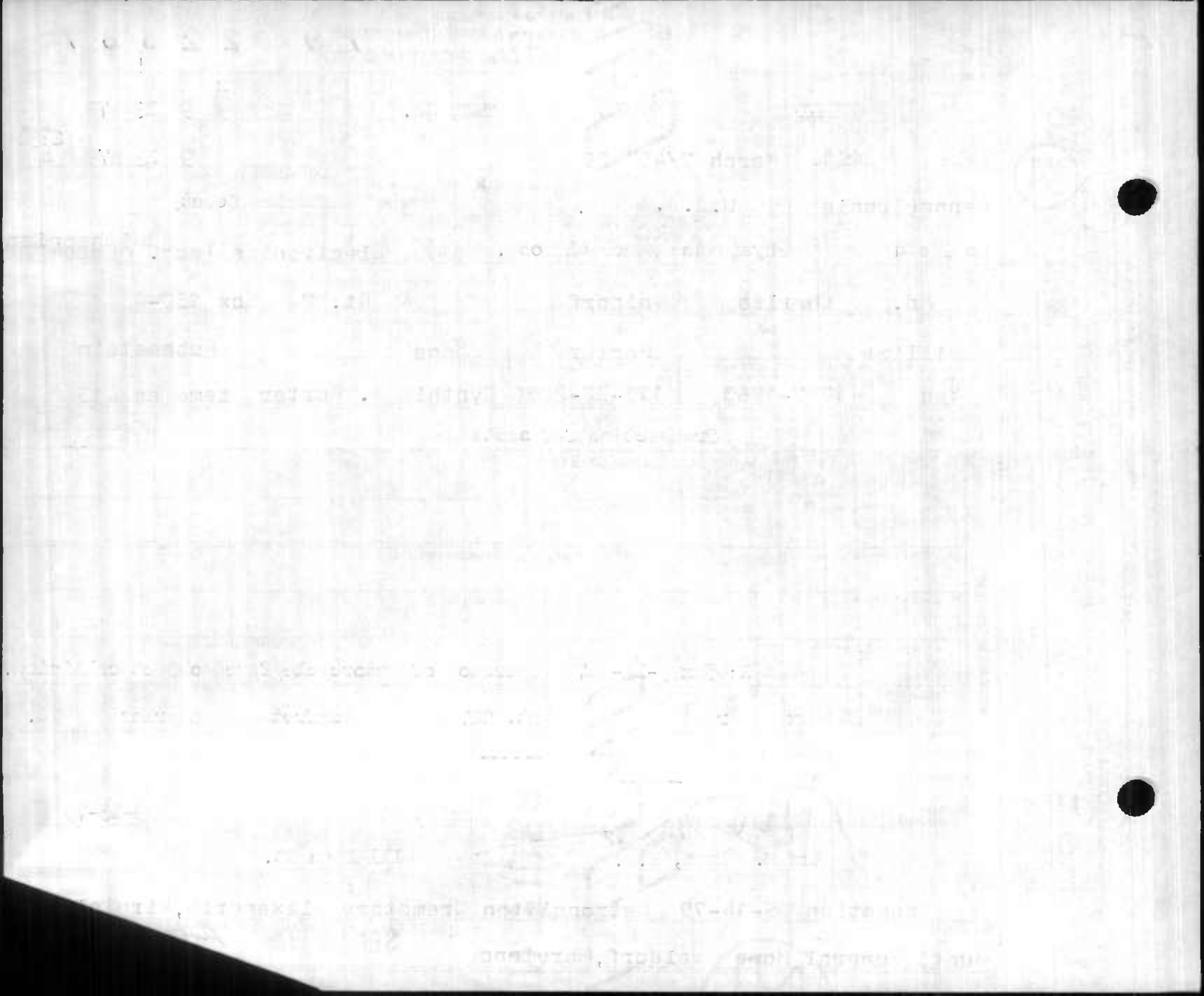
1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		X MONTH		9 13 1979		26. HOUR	
WILLIAM		RUSSELL		PORTER, SR.				20. DATE KNOWN OF DEATH		X MONTH		9 13 1979		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		20. DATE PRONOUNCED DEAD		26. HOUR	
male		white		March 7/40		39 YRS.		MONTHS		DAYS		9 13 1979		2:34 a M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		X NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Pennsylvania		U.S.A.										Charles County			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						Smithsonian			
La Plata		Physicians Memorial Hosp. (DOA)		Electronics Tech.		Museum									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Md.		Charles		Waldorf		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. #2 Box 130-A							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME													
William		Edna													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
Yes		1957-1963		173-32-2096		Cynthia A. Porter same as #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a)															
8152															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?											
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
		1:45xx 9-13-79		Operator of motorcycle/fixed object collision.											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION											
		road		Rt. 227		Pomfret		Charles		Md.					
22a. I certify that I took charge of the remains described above, held on death resulted from:		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED											
Ann M. Dixon, M.D.		Assistant		9-12											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION									
Cremation		9-14-79		Metropolitan Crematory Alexandria											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE RECEIVED BY REGISTRAR											
Huntt Funeral Home		Waldorf, Maryland		SEP 19 1979											

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGES 4 AND 5 SHOULD BE KEPT BY THE MEDICAL EXAMINER. ATTACH THE CERTIFICATE TO THE MEDICAL EXAMINER'S REPORT AND ALL OTHER FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT BY THE DIRECTOR. PAGES 4 AND 5 SHOULD BE KEPT BY THE DIRECTOR. **TO THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 100 WEST PATTERSON STREET, BALTIMORE, MARYLAND, 21201** PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

DHMH - 16 60M 1/75  
(VRA 15 (4))

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				9 2 2 6 8 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Clifford Noel Snow</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>9- 11 79</b> 2b. HOUR <b>4:57aM</b>			
3. SEX <b>Male</b>		4. RACE <b>02</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 28 10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR DISTRICT OR FOREIGN COUNTRY) <b>N.H. Manchester</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD	
10. CITY OR TOWN OF DEATH <b>La Plata</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Const. Engineer S.H.A.</b>	
13a. STATE <b>Md</b>				13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Port Tobacco</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ernest Harland Snow</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Burke</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>WW11 216-10-0648</b>		17. INFORMANT ADDRESS <b>Emma Mae Snow same as #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4280 Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11 Sept 79</b> to <b>11 Sept 79</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Barry S. Reed MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>9-11-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Barry S. Reed, MD</b>				22e. ADDRESS <b>La Plata, Md. 20646</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-14-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls Ch. Cem.</b>		23d. LOCATION CITY OR TOWN <b>Waldorf</b>	
24. FUNERAL DIRECTOR NAME <b>Huntt Funeral Home</b>				ADDRESS <b>Waldorf, Md.</b>		25a. DATE REC'D. BY REGISTRAR 25b. BY <b>SEP 17 1979</b>	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 2 2 6 8 9

FOR  
1- STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Annie C. Thompson</b>			2a DATE OF DEATH MONTH DAY YEAR <b>9 9 79</b>		2b HOUR <b>10:20a</b>
3 SEX <b>female</b>	4 RACE <b>1</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>4-25-21</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS	
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7c CITIZEN OF WHAT COUNTRY? <b>United States</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Charles County MD</b>	
10 CITY OR TOWN OF DEATH <b>La Plata</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>none</b>	
12b KIND OF BUSINESS OR INDUSTRY <b>none</b>		13a STATE <b>MD</b>		13b COUNTY <b>Charles</b>	
13c CITY OR TOWN <b>La Plata</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <b>St. Rt. 2 Box 2327 La Plata, mD</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Carl Savoy</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Irene PROCTOR</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	
16b SOCIAL SECURITY NO. <b>215-30-5310</b>		17 INFORMANT <b>SANDRA GUTRICK</b>		ADDRESS <b>Box 75-D Nelson Pt. RD. Piquette, MD.</b>	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Rheumatoid Arthritis, Chronic obstructive Lung Disease</b>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>July 19 74</b> to <b>9-7-19 79</b> , that (I) (we) lost saw the deceased alive on <b>9-7-19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>G.S. Rath</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G.S. Rath, MD</b>		22e. ADDRESS <b>Waldorf Professional Bldg. Waldorf, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9-12-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. CHARLES</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>GLYMONT CHARLES MD.</b>					
24 FUNERAL DIRECTOR NAME <b>LEON THORNTON</b>		ADDRESS <b>P.O. Box 18115 Pomonkey, MD.</b>		25 DATE RECEIVED BY REGISTRAR <b>SEP 11 1979</b>	
26 SIGNATURE OF REGISTRAR <b>Thornton</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 2 6 9 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>OLA Wright</b>			2a DATE OF DEATH MONTH DAY YEAR <b>9-15-79</b>			2b HOUR MIN <b>10<sup>35</sup> M</b>	
3 SEX <b>F</b>		4 RACE <b>W</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>5 28 1903</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Charles County</b> MD	
10 CITY OR TOWN OF DEATH <b>La Plata, Md</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Charles County Nursing Home</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
13a STATE <b>MD</b>		13b COUNTY <b>Charles</b>		13c CITY OR TOWN <b>Nanjemoy</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Walter M. Thompson</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bertha Simmons</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
16b SOCIAL SECURITY NO. <b>215-38-6854</b>		17 INFORMANT ADDRESS <b>Indian Head, Christine Scott-Rt. 1, Box 179 Z MD. 20640</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF - (b) <b>CVA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Atherosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>August 19 78</b> to <b>9-15</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>9-15</b> 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Henry L. Burke M.D.</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>9-15-79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Henry L. Burke, M.D.</b>				22e. ADDRESS <b>La Plata, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-18-1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Nanjemoy Baptist Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Nanjemoy Charles Maryland</b>	
24. FUNERAL DIRECTOR <b>Archert Funeral Home, Inc. La Plata, MD.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 19 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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